

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

08339

Reg. Dist. No.

8341

1. PLACE OF DEATH a. COUNTY <u>Queen Annes</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Annes</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centerville</u>			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Centerville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JEFFREY ALLAN CAHALL</u>				4. DATE OF DEATH Month Day Year <u>July 13 1958</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept-11-1915</u>	
9. AGE (In years last birthday) <u>42</u> yrs.		10. UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Chester Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Ellen Noble Cahall</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ellen Cabbage</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Ellen N. Cahall Father Centerville Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured knee - hit by auto</u> <u>812X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>7/13/58</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Centerville Md</u>		20f. (City or town) (County) (State) <u>Centerville</u> <u>Queen Annes</u> <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>W. Henry Fisher</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>W HENRY FISHER</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <u>II</u>			
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 16-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Chesterfield</u>		22d. LOCATION (City, town, or county) (State) <u>Centerville</u> <u>Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Howard Babin</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 17 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Centerville</u>	

MEDICAL CERTIFICATION

17

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be retained as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: John J. Smith

2. Age: 45 Sex: Male

3. Date of Death: Jan 15, 1910

4. Place of Death: Home

5. Cause of Death: Myocardial Infarction

6. Duration of Illness: 2 weeks

7. Name of Physician: Dr. J. H. Brown

8. Name of Medical Examiner: Dr. J. H. Brown

9. Signature of Medical Examiner: [Signature]

10. Date of Examination: Jan 15, 1910

11. Name of Coroner: Mr. J. H. Brown

12. Name of Jury: Mr. J. H. Brown

13. Name of Witnesses: Mr. J. H. Brown

14. Name of Undertaker: Mr. J. H. Brown

15. Name of Burial Place: St. John's Cemetery

16. Name of Burial Date: Jan 16, 1910

17. Name of Burial Place: St. John's Cemetery

18. Name of Burial Date: Jan 16, 1910

19. Name of Burial Place: St. John's Cemetery

20. Name of Burial Date: Jan 16, 1910

## CERTIFICATE OF DEATH

Reg. Dist. No.

08340

8342

1. PLACE OF DEATH o. COUNTY <u>Queen Anne</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stevensville</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stevensville</u>	
		f. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>Edna</u> First <u>A</u> Middle <u>Dorsey</u> Last		4. DATE OF DEATH Month <u>7</u> Day <u>29</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-28-87</u>
9. AGE (In years lost birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Wright</u>		14. MOTHER'S MAIDEN NAME <u>Ida Harris</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>—</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>017-16-1495</u>	
17. INFORMANT <u>Bessie Tolson</u>		Address <u>Stevensville, md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X cerebral Thrombosis</u> DUE TO <u>Arteriosclerosis general + cerebral</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Hypertensive Cardio-vascular disease</u> DUE TO <u>2 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>July 28, 1958</u> <u>3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Vitiligo many years standing</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 10, 1956</u> to <u>July 29, 1958</u> , that I last saw the deceased alive on <u>July 28, 1958</u> , and that death occurred at <u>10:30 P.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>Stevensville md.</u> DATE SIGNED <u>July 30, 1958</u>	
ACTUAL SIGNATURE <u>Theodor Sattelmair</u> M.D.		PHYSICIAN'S NAME (Type) <u>THEODOR SATTELMAYER</u> <u>STEVENSVILLE, MARYLAND</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>8/3/58</u>	<u>Stevensville, Cem</u>	<u>Stevensville, md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Schell, Eaton, md.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 7 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Alfred</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the funeral-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK—COUNTY OF ALBANY

2014-21-710

8343

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>QUEEN ANNE'S</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>QUEEN ANNE'S</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PRICE</u>		c. LENGTH OF STAY IN 1b <u>17 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>Augusta</u> Last <u>GROSS</u>		4. DATE OF DEATH Month <u>July</u> Day <u>1</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 11 - 1886</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR: Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HENRY Wilson</u>		14. MOTHER'S MAIDEN NAME <u>MARY Jackson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-18-4928</u>	
17. INFORMANT <u>EMORY GROSS</u>		Address <u>CENTREVILLE, MARYLAND</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c) <u>Arteriosclerosis Generalized</u>		INTERVAL BETWEEN ONSET AND DEATH <u>March, 1958</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis Generalized</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>o. m.</u> <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 7, 1958</u> to <u>July 1, 1958</u> that I last saw the deceased alive on <u>June 27, 1958</u> , and that death occurred at <u>1:30</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. R. Layton</u> M.D.		DATE SIGNED <u>July 3, 1958</u>	
PHYSICIAN'S NAME (Type) <u>C. R. Layton</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>July 3, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Brownsville Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Rural Centreville Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James H. Butler Jr. of Butler Bros., Centreville Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 7 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Quincy</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
John Doe		Male		45	
Date of Death		Place of Death		Cause of Death	
Jan 15, 1920		New York City		Heart Disease	
Time of Death		Occupation		Signature of Physician	
10:30 AM		Teacher		[Signature]	
Name of Informant		Relationship		Signature of Informant	
Jane Doe		Wife		[Signature]	
Name of Burial Place		Name of Undertaker		Name of Funeral Home	
Cemetery		Doe & Sons		123 Main St	
Name of Minister		Name of Pastor		Name of Rector	
[Signature]		[Signature]		[Signature]	

Witnessed and attested at the City of New York, County of New York, on the 15th day of January, 1920.

Notary Public for the State of New York

[Signature]

## BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8344

## CERTIFICATE OF DEATH

08342

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centerville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centerville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>VINCENT</u> Middle <u>HARRIS</u> Last <u>HARRIS</u>				4. DATE OF DEATH Month <u>July</u> Day <u>4</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 20 - 1893</u>	9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fireman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cannery</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Do not know</u>				14. MOTHER'S MAIDEN NAME <u>Do not know</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>219-07-7109</u>		17. INFORMANT <u>Mamie Harris</u> Address <u>Centerville Md</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Paralysis Right Side</u> <u>450.0</u> DUE TO <u>Alcoholism</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>He had auto accident in May</u> DUE TO (c) <u>He had auto accident in May</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 20, 1958</u> to <u>July 7, 1958</u> that I last saw the deceased alive on <u>July 7, 1958</u> and that death occurred at <u>4:00 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H.F. McPherson</u> M.D.				ADDRESS (Street, city or town, state) <u>Centerville Md</u> DATE SIGNED <u>7/5/58</u>			
PHYSICIAN'S NAME (Type) <u>H.F. McPherson</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 7-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Chestnut</u>		22d. LOCATION (City, town, or county) (State) <u>Centerville Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Bach of Baltimore</u> ADDRESS <u>Centerville Md</u>				24a. REC'D BY REGISTRAR <u>ALL</u> DATE <u>JUL 8 '58</u>		24b. REGISTRAR'S SIGNATURE <u>ALL</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Pages 2 and 3 should be filed with the funeral director. After this certificate is signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1924

Name of Deceased		Sex		Age	
John J. Smith		Male		45	
Residence		Occupation		Cause of Death	
123 Main St., Boston		Carpenter		Heart Disease	
Date of Death		Place of Death		Time of Death	
Jan 15, 1924		Home		10:30 AM	
Physician		Burial		Interment	
Dr. J. B. Jones		St. Paul's Church		Cemetery	
Signature of Physician		Signature of Registrar		Signature of Minister	
[Signature]		[Signature]		[Signature]	

## 8345 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>QUEEN ANNE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>QUEEN ANNE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MILLINGTON</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>RD. #1</u>	
3. NAME OF DECEASED (Type or print) <u>SAMUEL</u> First <u>JOHNSON</u> Middle <u>JOHNSON</u> Last		4. DATE OF DEATH <u>JULY 23</u> 19 <u>58</u> Month Day Year	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>COL.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 2, 1894</u> 63 yrs.
9. AGE (In years last birthday) <u>63</u> yrs.		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARM WORK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HENRY JOHNSON</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-16-5079</u>	
17. INFORMANT <u>ETHEL DEMBY</u> Address <u>RD. #1 MILLINGTON, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Cardiovascular Disease</u> <u>422.11</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Atherosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Anaemia</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u> <u>8 years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>No injury</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 <u>58</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Apr 7</u> , 19 <u>56</u> , to <u>July 23</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>July 21</u> , 19 <u>58</u> , and that death occurred at <u>6:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. H. Hamilton</u>		DATE SIGNED <u>July 25/58</u>	
PHYSICIAN'S NAME (Type) <u>H. H. HAMILTON</u>		<u>MILLINGTON</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>7/26/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>PILEYS NECK CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>MILLINGTON, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Hellows, Millington, Md.</u>		24a. REC'D BY REGISTRAR <u>JUL 28 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Chas. Smith</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. This certificate has been signed by the attending physician and completely filled out by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1

*[Faint, mostly illegible text and lines on a death certificate form. Some visible words include:]*

*NAME*  
*AGE*  
*SEX*  
*DATE OF BIRTH*  
*PLACE OF BIRTH*  
*DATE OF DEATH*  
*PLACE OF DEATH*  
*Cause of Death*  
*Signature*  
*Witness*

FOR STATE  
HEALTH DEPT.

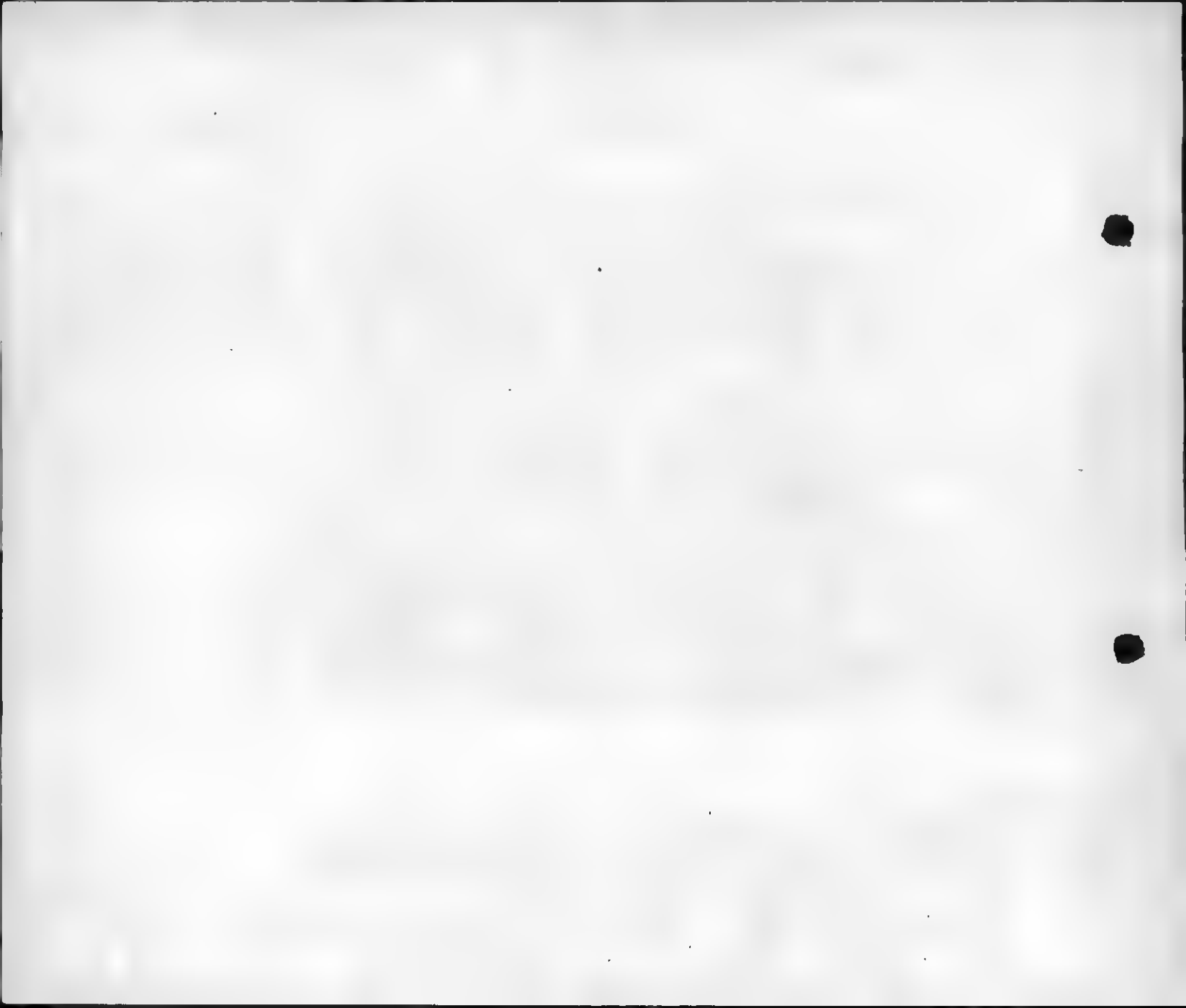
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08344

8346 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Ind.</u> b. COUNTY <u>Queen Anne's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centerville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centerville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>Mary Eliz King</u>		4. DATE OF DEATH <u>July 6 1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 18-1892</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. FUNDING YEAR <u>65</u> Months <u>6</u> Days <u>6</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Queen Anne Co Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Chas Wright</u>		14. MOTHER'S MAIDEN NAME <u>Mary Eliz Handy</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO <u>165-14-046</u>	
17. INFORMANT <u>Newton H. Hollis (daughter)</u>		Address <u>Centerville Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>W. Henry Fisher</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>W. HENRY FISHER</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>7/8-58</u>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>July 8, 58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Chestnutfield</u>		22d. LOCATION (City, town, or county) (State) <u>Centerville Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Edward Barton</u>		24a. REC'D BY REGISTRAR <u>Barton</u>	
24b. REGISTRAR'S SIGNATURE <u>Centerville Md</u>		DATE <u>JUL 9 '58</u>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any. If necessary, please execute the certificate, writing the words "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2 57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8347 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08345

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>QUEEN ANNE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>QUEEN ANNE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHURCH HILL</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHURCH HILL</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>WILLARD</u> First <u>MOSSMAN</u> Middle <u>MOSSMAN</u> Last		4. DATE OF DEATH <u>JULY</u> Month <u>6</u> Day <u>1958</u> Year	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 26 - 1885</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED GEN. SALES MGR. MASS</u>		11. BIRTHPLACE (State or foreign country) <u>MASS</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>A. E. MOSSMAN</u>	
14. MOTHER'S MAIDEN NAME <u>MARY ECOTT</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>MRS. MOSSMAN = CHURCH HILL MD.</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> (c) <u>420.1</u> DUE TO <u>Coronary Occlusion</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>420.1</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <u>W. Henry Fisher</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>7-7-58</u>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JULY 8</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ST. LUKES</u>		22d. LOCATION (City, town, or county) (State) <u>CHURCH HILL MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane</u> ADDRESS <u>Church Hill, Md.</u>		24a. REC'D BY REGISTRAR <u>JUL 10 '58</u> DATE	
24b. REGISTRAR'S SIGNATURE <u>W. Henry Fisher</u>		24c. REGISTRAR'S SIGNATURE	



8348

## MEDICAL CERTIFICATION

VS. A15ME(S)  
SM 9/55



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08347

## 8349 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Queen Anne</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Queen Anne</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Nr. Sudlersville, Md.</b>		c. LENGTH OF STAY IN TB <b>years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>At Home</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>James A. Simpler</b>		4. DATE OF DEATH <b>July 14, 1958</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 11, 1881</b>
9. AGE (In years last birthday) <b>77</b> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer &amp; Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Laborer</b>	
11. BIRTHPLACE (State or foreign country) <b>Kent Co. Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William H. Simpler</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Amanda Merideth</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>215-20-0247</b>	
17. INFORMANT <b>A</b>		18. ADDRESS <b>Sudlersville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Corbital Hemorrhage</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Corbital Arterial Sclerosis</b> (c) <b>Chronic Myocarditis</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Smile</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>(W)</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour a. m. <b>20</b> 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 19, 1958</b> to <b>July 14, 1958</b> , that I last saw the deceased alive on <b>July 12, 1958</b> , and that death occurred at <b>7:24 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>C. H. Metcalfe</b>		DATE SIGNED <b>July 14 1958</b>	
PHYSICIAN'S NAME (Type) <b>C. H. Metcalfe</b>		ADDRESS <b>Sudlersville, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 16, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Chester Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Chestertown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Willis Wells</b>		ADDRESS <b>Chestertown, Md.</b>	
24a. REC'D BY REGISTRAR <b>Aug 1 1958</b>		24b. REGISTRAR'S SIGNATURE <b>W. L. Smith</b>	

CERTIFICATE OF DEATH

WILLIAM J. BROWN

Form with multiple lines for text entry, including fields for name, date, and cause of death.

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

8350

## CERTIFICATE OF DEATH

08348

Reg. Dist. No. ....

1. PLACE OF DEATH COUNTY <u>Queen Anne</u> MARYLAND CITY OR TOWN <u>Rural Chestertown</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Queen Anne</u> CITY OR TOWN <u>Rural Chestertown</u> STREET ADDRESS <u>/</u> (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>Hulda</u> (First) <u>Stevens</u> (Middle) (Last)			4. DATE OF DEATH July 12 19 58 (Month) (Day) (Year)				
5. SEX <u>Fem.</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Mar. 19-1870</u>	9. AGE last birthday <u>88</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>John Jones</u>			14. MOTHER'S MAIDEN NAME <u>Bostic</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Clayton Stevens--Chestertown, Md.</u>			
18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>422.1 IMMEDIATE CAUSE (A) Cardiac Dilatation</u> ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <u>Chronic Myocarditis</u> <u>Arterial Sclerosis</u> 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Senility</u>				INTERVAL BETWEEN ONSET AND DEATH			
19a. DATE OF OPERATION <u>24</u>		19b. MAJOR FINDINGS OF OPERATION <u>7</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <u>24</u> M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 1958</u> to <u>July 12, 1958</u> , that I last saw the deceased alive on <u>July 4, 1958</u> , and that death occurred at <u>1:45 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>W. H. Hufschmidt</u>		M. D. <u>W. H. Hufschmidt</u>		DATE SIGNED <u>7/14/58</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>July 14</u>		NAME OF CEMETERY OR CREMATORY <u>Crumpton</u>			
24. REC'D BY REGISTRAR DATE <u>JUL 16 '58</u>		REGISTRAR'S SIGNATURE <u>Edgar L. Lane</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane</u> ADDRESS <u>Church Hill, Md.</u>			

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS  
B-11  
CERTIFICATE OF DEATH

MASSACHUSETTS

1. Name of deceased: \_\_\_\_\_  
2. Sex: \_\_\_\_\_  
3. Date of birth: \_\_\_\_\_  
4. Place of birth: \_\_\_\_\_  
5. Date of death: \_\_\_\_\_  
6. Place of death: \_\_\_\_\_  
7. Cause of death: \_\_\_\_\_  
8. Manner of death: \_\_\_\_\_  
9. Signature of attending physician: \_\_\_\_\_  
10. Signature of registrar: \_\_\_\_\_  
11. Date of registration: \_\_\_\_\_